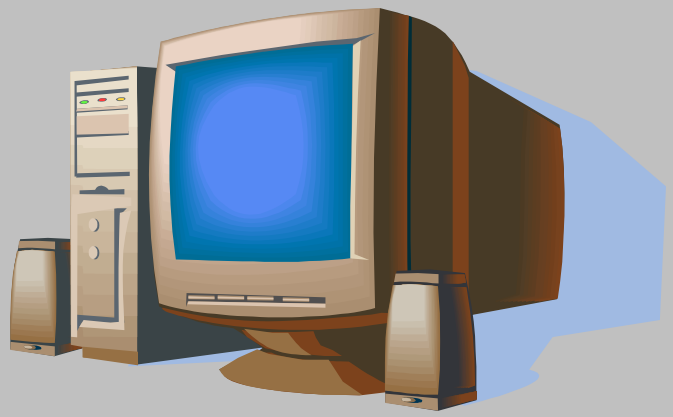
ARMY BENEFITS CENTER-CIVILIAN
FORT RILEY, KANSAS

COMPLETING THE CIVILIAN SERVICE RETIREMENT SYSTEM (CSRS) DISABILITY RETIREMENT APPLICATION

WHERE DO I FIND THE FORMS ?

- Army Benefits Center-Civilian website at https://www.abc.army.mil
- Employee Benefits Information System (EBIS)
- The Office of Personnel Management (OPM) at http://www.opm.gov/forms
- Call a counselor (1-877-276-9287)



CSRS IMMEDIATE RETIREMENT FORMS

- SF 2801 Application for Immediate Retirement CSRS
  Schedules A, B, C (if applicable)
  SF 2801-2 Spouse's Consent to Survivor Election (if applicable)

- SF 2818 Continuation of Life Insurance Coverage

- W-4P Federal Tax Withholding

- DD 214 (if applicable)

- OPM 1515 Military Service Deposit Election Form or proof of military deposit i.e. OPM 1514 Military Deposit Worksheet

- Marriage Certificate (if applicable)

SF 2801 – SECTION A
IDENTIFYING INFORMATION

CSRS

Application for Immediate Retirement

Civil Service Retirement System

See Privacy Act Information on Instruction Sheet

Section A - Identifying Information

1. Name *(last, first, middle)*	2. List all other names you have used	
3. Address *(number, street, city, state, ZIP code)*	4a. Daytime area code and telephone number after retirement ( )	4b. Best time to reach you
	4c. Home Email address	4d. FAX number ( )
	5. Date of birth *(mm/dd/yyyy)*	6. All social security numbers you have used.
7. Are you a citizen of the United States of America? ☐ Yes ☐ No	8. Is this an application for disability retirement? ☐ Yes *(Ask your employing office about other documents you must submit)* ☐ No	

SF 2801 – SECTION B
FEDERAL SERVICE

Section B - Federal Service

1. Department or agency from which you are retiring *(Include bureau or division)*

2. Date of final separation *(mm/dd/yyyy)*

1a. Address and ZIP code

3. Title of position from which you are retiring

3a. Your pay plan and occupational series

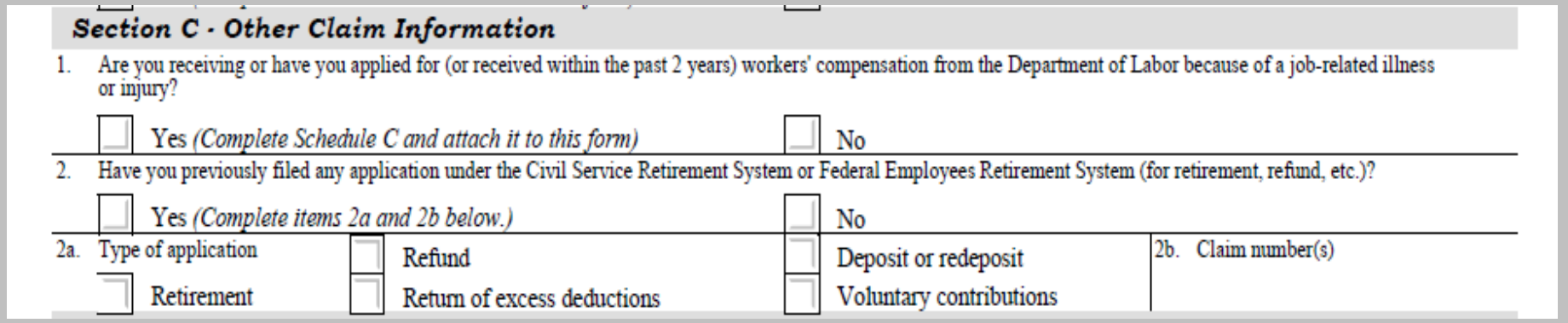
4. Have you performed active honorable service in the Armed Forces or other uniformed services of the United States *(see SF 2801A for definitions)*?

☐ Yes *(Complete Schedule A and attach it to this form)* ☐ No

5. Are you receiving or have you applied for military retired pay? (Note: If you later become entitled to military retired pay, you must notify OPM.)

☐ Yes *(Complete Schedule B and attach it to this form)* ☐ No

SF 2801 – SECTION C
OTHER CLAIM INFORMATION



Section C - Other Claim Information

1. Are you receiving or have you applied for (or received within the past 2 years) workers' compensation from the Department of Labor because of a job-related illness or injury?

☐ Yes *(Complete Schedule C and attach it to this form)* ☐ No

2. Have you previously filed any application under the Civil Service Retirement System or Federal Employees Retirement System (for retirement, refund, etc.)?

☐ Yes *(Complete items 2a and 2b below.)* ☐ No

2a. Type of application				2b. Claim number(s)
☐ Retirement	☐ Refund	☐ Return of excess deductions	☐ Deposit or redeposit	☐ Voluntary contributions	

SF 2801 – SECTION D
INSURANCE INFORMATION

Section D - Insurance Information See the pamphlet SF 2801A, *Applying for Immediate Retirement Under the Civil Service Retirement System*, for information.

1. Are you eligible to continue Federal Employees Health Benefits coverage as a retiree?

☐ Yes ☐ No

2. Does a court or administrative order require that you provide health benefits coverage for one or more children?

☐ No ☐ Yes *(Attach a copy of the order.)*

3. Are you eligible to continue Federal Employees' Group Life Insurance coverage as a retiree?

☐ Yes ☐ No

4. Are you currently enrolled in the Federal Long Term Care Insurance Program (FLTCIP)?

☐ Yes → *You will automatically continue your coverage into retirement, as long as you continue to pay applicable premiums. If you are currently paying FLTCIP premiums by agency payroll deduction, you must arrange to pay premiums, either by deductions from your annuity, through automatic bank debit, or direct bill. Please call LTC Partners at 1-800-LTC-FEDS (1-800-582-3337) to make these arrangements.*

☐ No

SF 2801 – SECTION E
MARITAL INFORMATION

Section E - Marital Information *(All applicants must complete questions 1 and 2 below.)*

1. Are you married now? *(A marriage exists until ended by death, divorce, or annulment. You must notify the Office of Personnel Management if this marriage ends.)*

☐ Yes *(Complete items 1a - 1f and attach a copy of your marriage certificate)* ☐ No *(Go to item 2)*

1a. Spouse's name *(last, first, middle)*		1b. Spouse's date of birth *(mm/dd/yyyy)*	1c. Spouse's social security number(s)
1d. Place of marriage *(city, state)*	1e. Date of marriage *(mm/dd/yyyy)*	1f. Marriage performed by:	☐ Clergyman or Justice of Peace ☐ Other *(explain)*:

2. Do you have a living former spouse(s) from whom you were divorced on or after May 7, 1985, and to whom a court order gives a survivor annuity?

☐ Yes *(Attach a certified copy of the court order[s] and any amendments.)* ☐ No

SF 2801 – SECTION F
ANNUITY ELECTION

Section F - Annuity Election

Make your election by initialing the box beside the type of annuity you want to receive and give any other information requested. Read the attached information on pages 2 through 5 and the explanations below and consider your election carefully. No change will be permitted after your annuity is granted except as explained on pages 7 and 8 of the attached instructions. If you are married at retirement, the law provides an annuity with full survivor benefits for your spouse unless your spouse consents to your election not to provide maximum survivor benefits. An election for your spouse ends if your marriage ends by death, divorce, or annulment.

1.	*Initials*	***I choose a reduced annuity with maximum survivor annuity (equal to 55% of my basic annuity) for my spouse named in Section E. 1a.*** If you are married at retirement, you will receive this type of annuity unless your spouse consents to your election not to provide maximum survivor benefits. If your marriage ends by death, divorce, or annulment, this election terminates and you must notify the Office of Personnel Management.
2.	*Initials*	***I choose a reduced annuity with a partial survivor annuity (equal to 55% of $_____ a year) for my spouse named in Section E. 1a.*** If you choose this option, the amount you enter must be less than your annual annuity. You ***must*** have your spouse's consent. Complete SF 2801-2, *Spouse's Consent to Survivor Election*, and attach it to your application. If your marriage ends by death, divorce, or annulment, this election terminates and you must notify the Office of Personnel Management.

SF 2801 – SECTION F
ANNUITY ELECTION

Formula for the Partial Survivor Annuity

Desired monthly amount x 12 / .55 = Amount (Section F, question #2)

Example:

Desired Monthly Amount for Spouse: $500

$500 x 12 = $6,000

$6000 / .55 = $10,909

$10,909 is the amount to be placed in the blank for Section F, question #2

SF 2801 – SECTION F
ANNUITY ELECTION

3.	***Initials***	***I choose an annuity payable only during my lifetime.*** If you are married at retirement, you ***cannot*** choose this type of annuity without your spouse's consent. ***No survivor annuity will be paid to your spouse after your death if he or she consents to this election and any health benefits will cease. In addition, your spouse will not be eligible to enroll in the Federal Long Term Care Insurance Program, if he/she is not enrolled at the time of your death.*** If you are married and elect this type of annuity, complete SF 2801-2, *Spouse's Consent to Survivor Election*, and attach it to your application.
4.	***Initials***	***I choose a reduced annuity with survivor annuity for the person named below who has an insurable interest in me.*** You must be healthy and willing to provide medical evidence if you choose this type of annuity. *(Disability annuitants are not eligible to choose this type of annuity.)* If you are married and elect this type of annuity, complete SF 2801-2, *Spouse's Consent to Survivor Election*, and attach it to your application.

Name of person with insurable interest	Relationship to you	Date of birth *(mm/dd/yyyy)*	Social security number

5.	***Initials***	***I choose a reduced annuity with survivor annuity for my former spouse(s) or for my spouse and former spouse(s) shown below.*** You must attach: (1) Copies of divorce decrees for all former spouses for whom you elect to provide a survivor annuity. (2) If you are married, attach a completed SF 2801-2, *Spouse's Consent to Survivor Election*. You cannot choose this option and provide a maximum survivor annuity for your spouse (Box 1). An election for a former spouse ends if your former spouse dies or remarries before age 55, unless you were married for 30 years or longer. If one of these events occurs, this election terminates and you must notify the Office of Personnel Management.

Name and address of current spouse			Survivor annuity equal to _____% of my annuity
Name and address of former spouse	Date of marriage *(mm/dd/yyyy)*	Date of divorce *(mm/dd/yyyy)*	Survivor annuity equal to _____% of my annuity
	Date of birth *(mm/dd/yyyy)*	Social security number	
Name and address of former spouse	Date of marriage *(mm/dd/yyyy)*	Date of divorce *(mm/dd/yyyy)*	Survivor annuity equal to _____% of my annuity
	Date of birth *(mm/dd/yyyy)*	Social security number	

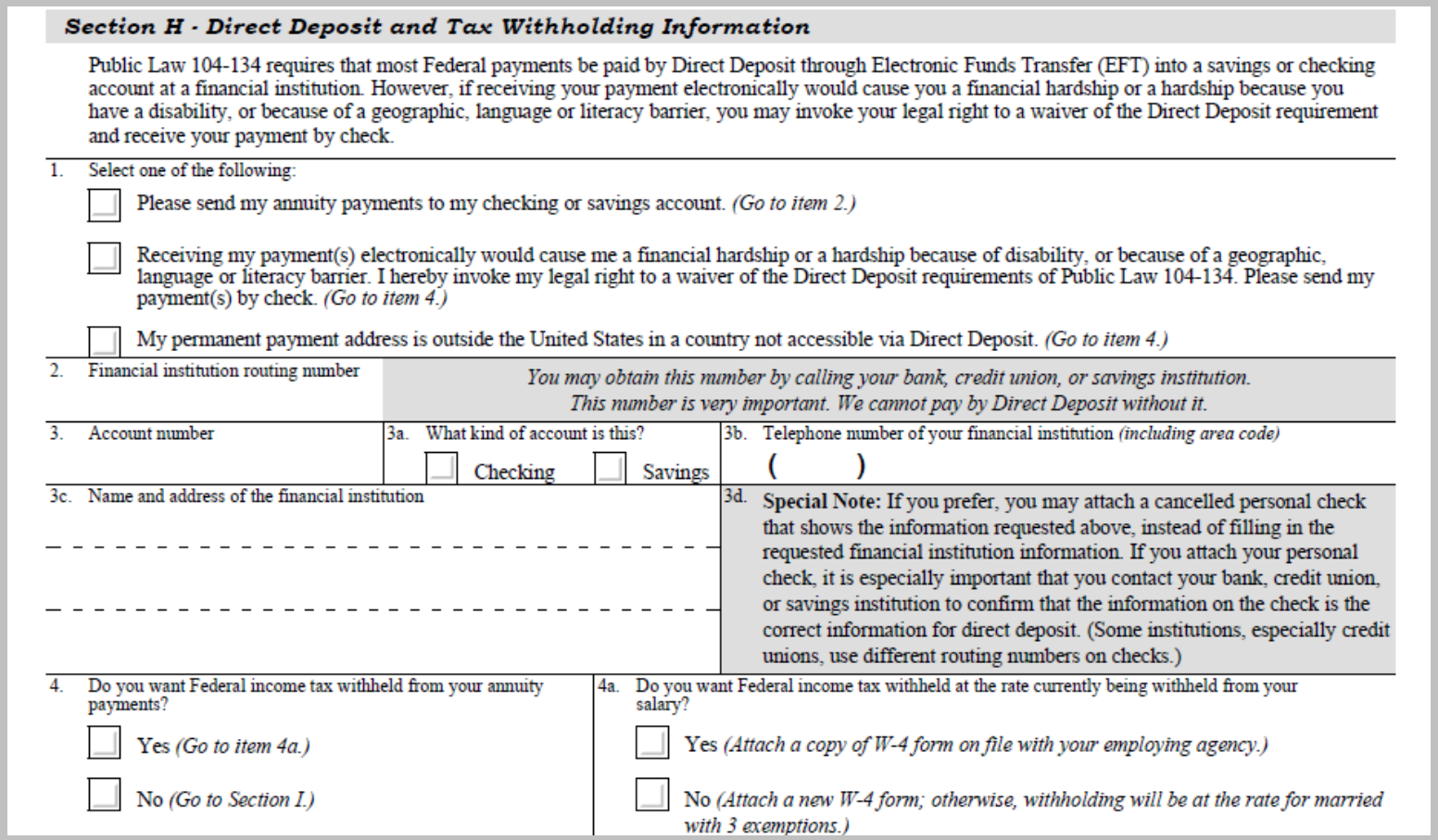
Total ***(cannot exceed 55% of your unreduced annuity)*** → _____0%

SF 2801 – SECTION G
INFORMATION ABOUT YOUR UNMARRIED DEPENDENT CHILDREN

Section G (Optional) - Information About Your Unmarried Dependent Children

1. Dependent child's name *(first, middle, last)*	2. Date of birth *(mm/dd/yyyy)*	3. Disabled *(✓)*	1. Dependent child's name *(first, middle, last)*	2. Date of birth *(mm/dd/yyyy)*	3. Disabled *(✓)*

SF 2801 – SECTION H
DIRECT DEPOSIT AND TAX WITHHOLDING INFORMATION



Section H - Direct Deposit and Tax Withholding Information

Public Law 104-134 requires that most Federal payments be paid by Direct Deposit through Electronic Funds Transfer (EFT) into a savings or checking account at a financial institution. However, if receiving your payment electronically would cause you a financial hardship or a hardship because you have a disability, or because of a geographic, language or literacy barrier, you may invoke your legal right to a waiver of the Direct Deposit requirement and receive your payment by check.

1. Select one of the following:

☐ Please send my annuity payments to my checking or savings account. *(Go to item 2.)*

☐ Receiving my payment(s) electronically would cause me a financial hardship or a hardship because of disability, or because of a geographic, language or literacy barrier. I hereby invoke my legal right to a waiver of the Direct Deposit requirements of Public Law 104-134. Please send my payment(s) by check. *(Go to item 4.)*

☐ My permanent payment address is outside the United States in a country not accessible via Direct Deposit. *(Go to item 4.)*

2. Financial institution routing number — *You may obtain this number by calling your bank, credit union, or savings institution. This number is very important. We cannot pay by Direct Deposit without it.*

3. Account number

3a. What kind of account is this? ☐ Checking ☐ Savings

3b. Telephone number of your financial institution *(including area code)* ( )

3c. Name and address of the financial institution

3d. **Special Note:** If you prefer, you may attach a cancelled personal check that shows the information requested above, instead of filling in the requested financial institution information. If you attach your personal check, it is especially important that you contact your bank, credit union, or savings institution to confirm that the information on the check is the correct information for direct deposit. (Some institutions, especially credit unions, use different routing numbers on checks.)

4. Do you want Federal income tax withheld from your annuity payments?

☐ Yes *(Go to item 4a.)*

☐ No *(Go to Section I.)*

4a. Do you want Federal income tax withheld at the rate currently being withheld from your salary?

☐ Yes *(Attach a copy of W-4 form on file with your employing agency.)*

☐ No *(Attach a new W-4 form; otherwise, withholding will be at the rate for married with 3 exemptions.)*

SF 2801 – SECTION I
APPLICANT'S CERTIFICATION AND CHECKLIST

Section I - Applicant's Certification

Warning	*I hereby certify that all statements made in this application are true to the best of my knowledge and belief.*	
Any intentionally false statement in this application or willful misrepresentation relative thereto is a violation of the law punishable by a fine of not more than $10,000 or imprisonment of not more than 5 years, or both. (18 U.S.C. 1001)	Signature *(Do not print)*	Date *(mm/dd/yyyy)*

Applicant's Checklist

This checklist is provided to help you be certain you have attached all necessary documentation and to help your employing office be certain it forwards all of your retirement documentation to the Office of Personnel Management.	*Yes*	*No*	*Not Applicable*
1. **Military Service** - If you answered "yes" to Section B, Item 4, did you attach Schedule A?	☐	☐	☐
2. **Military Service** - If you completed Schedule A, did you attach a copy of your discharge certificate or other certificate of active military service?	☐	☐	☐
3. **Military Retired Pay** - If you answered "yes" to Section B, item 5, did you attach Schedule B?	☐	☐	☐
4. **Military Retired Pay** - If you completed Schedule B and answered "yes" to item 2 or 3, did you attach a copy of award or other documentation of the type of military retired pay you are receiving?	☐	☐	☐
5. **Military Retired Pay** - If you completed Schedule B and answered "yes" to item 4, did you attach a copy of your request for waiver and a copy of the military finance office's acknowledgment or approval of your request for waiver *(if applicable)*?	☐	☐	☐
6. **Survivor Election** - If you are married and did not initial box 1 of Section F, did you attach SF 2801-2, *Spouse's Consent to Survivor Election*?	☐	☐	☐
7. **Life Insurance** - If you answered "yes" to Section D, item 3, did you attach SF 2818, *Continuation of Life Insurance Coverage As an Annuitant or Compensationer*?	☐	☐	☐
8. **OWCP** - If you answered "yes" to Section C, item 1 did you attach Schedule C?	☐	☐	☐
9. **Tax** - If you want to elect a Federal Income Tax withholding rate, did you attach a W-4 form?	☐	☐	☐
10. **Court or Administrative Order(s)** - If you answered "yes" to Section E, item 2 did you attach a copy of the order(s)?	☐	☐	☐

SF 2801 SCHEDULES A, B & C
SCHEDULE A – MILITARY SERVICE INFORMATION

Schedules A, B and C

1. Name *(last, first, middle)*	2. Date of birth *(mm/dd/yyyy)*	3. Social security number

Schedule A - Military Service Information

1. If you have performed active honorable service in the United States Armed Services or other uniformed services, complete 1a - d below and attach a copy of your discharge certificate or other certificate of active military service *(if available)*.

a. Branch of service	b. Serial number	c. Dates of active duty		d. Last grade or rank
		From *(mm/dd/yyyy)*	To *(mm/dd/yyyy)*	

2. If any of your military service occured on or after January 1, 1957, have you paid a deposit to your agency for this service? (*You must pay this deposit to your agency. You cannot pay OPM after you retire.)*

☐ Yes ☐ No ☐ Not applicable

SF 2801 SCHEDULES A, B & C
SCHEDULE B – MILITARY RETIRED PAY

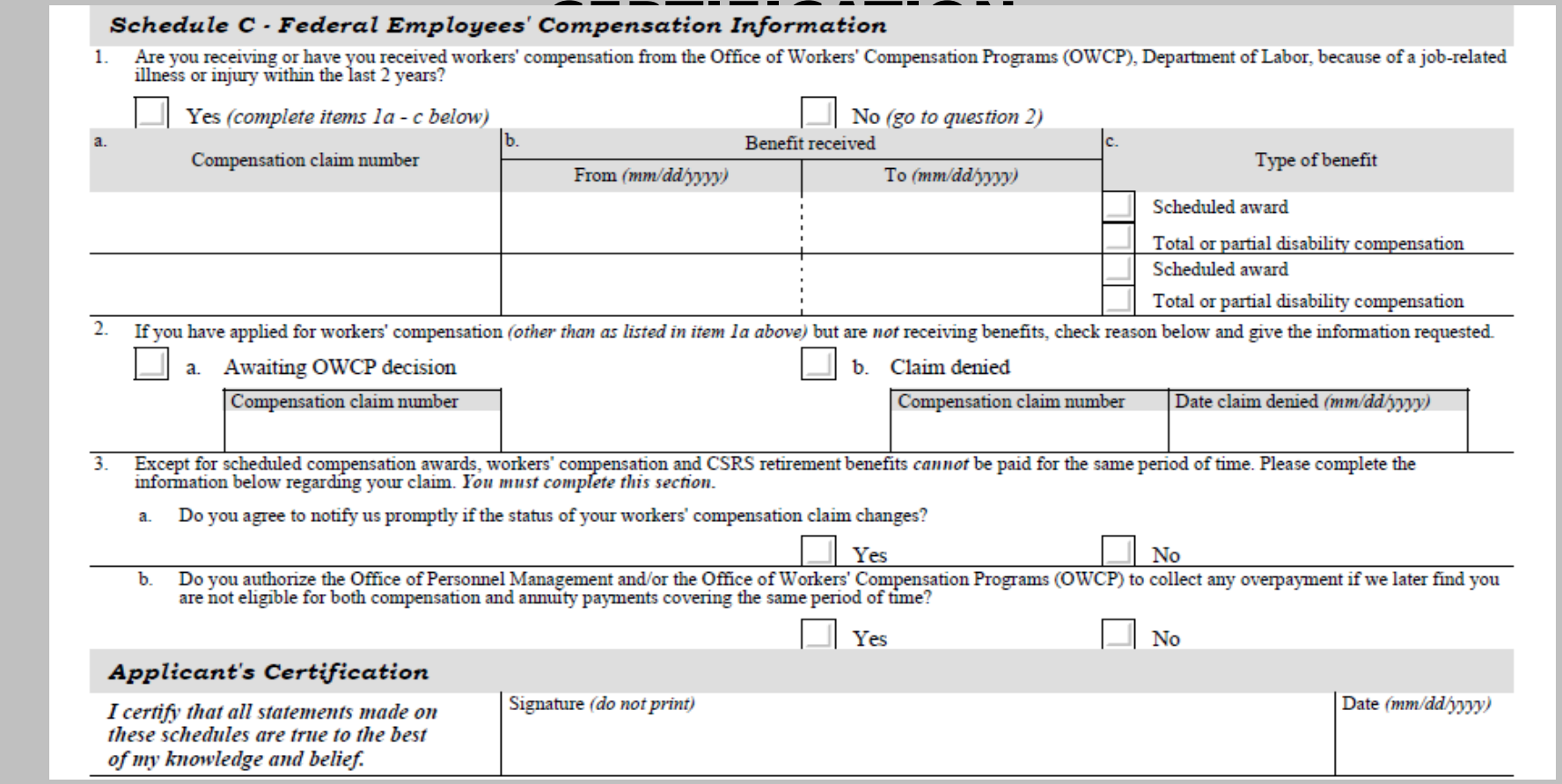
Schedule B - Military Retired Pay

If you are receving or have applied for military retired or retainer pay *(including disability retired pay)*, complete items 1 - 4 below.

1. Are you receiving or have you ever applied for military retired or retainer pay? *(Answer "yes" if you are receiving payments from the Department of Veterans Affairs instead of military retired pay.)* ☐ Yes ☐ No	2. Was your military retired or retainer pay awarded for reserve service under Chapter 1223, title 10, U.S. Code, Sections 12731 through 12739 *(formerly Chapter 67, title 10)*? ☐ Yes *(Attach a copy of notice of award.)* ☐ No
3. Was your military retired pay or retainer pay awarded for a disability incurred in combat or caused by an instrumentality of war and incurred in the line of duty during a period of war? ☐ Yes *(Attach a copy of notice of award.)* ☐ No	4. Are you waiving your military retired or retainer pay in order to receive credit for military service for CSRS retirement benefits? ☐ Yes *(Attach a copy of your request for waiver and a copy of military finance office's acknowledgment or approval of your request for waiver.)* ☐ No

SF 2801 SCHEDULES A, B & C

SCHEDULE C – FEDERAL EMPLOYEE'S COMPENSATION INFORMATION AND APPLICANT'S



Schedule C - Federal Employees' Compensation Information

1. Are you receiving or have you received workers' compensation from the Office of Workers' Compensation Programs (OWCP), Department of Labor, because of a job-related illness or injury within the last 2 years?

☐ Yes *(complete items 1a - c below)* ☐ No *(go to question 2)*

a. Compensation claim number	b. Benefit received From *(mm/dd/yyyy)*	b. Benefit received To *(mm/dd/yyyy)*	c. Type of benefit
			☐ Scheduled award ☐ Total or partial disability compensation
			☐ Scheduled award ☐ Total or partial disability compensation

2. If you have applied for workers' compensation *(other than as listed in item 1a above)* but are *not* receiving benefits, check reason below and give the information requested.

☐ a. Awaiting OWCP decision

Compensation claim number

☐ b. Claim denied

Compensation claim number	Date claim denied *(mm/dd/yyyy)*

3. Except for scheduled compensation awards, workers' compensation and CSRS retirement benefits *cannot* be paid for the same period of time. Please complete the information below regarding your claim. *You must complete this section.*

a. Do you agree to notify us promptly if the status of your workers' compensation claim changes?

☐ Yes ☐ No

b. Do you authorize the Office of Personnel Management and/or the Office of Workers' Compensation Programs (OWCP) to collect any overpayment if we later find you are not eligible for both compensation and annuity payments covering the same period of time?

☐ Yes ☐ No

Applicant's Certification

I certify that all statements made on these schedules are true to the best of my knowledge and belief.	Signature *(do not print)*	Date *(mm/dd/yyyy)*

SF 2801-2
SPOUSE'S CONSENT TO SURVIVOR ELECTION

Spouse's Consent to Survivor Election

Instructions: If you are married and you do not elect a reduced annuity to provide a maximum survivor annuity for your current spouse, complete Part 1. Have your spouse complete Part 2. Part 2 must be completed in the presence of a Notary Public or other person authorized to administer oaths. The person administering oaths must complete Part 3.

Part 1 - To Be Completed by the Retiring Employee

Name *(last, first, middle)*	Date of birth *(mm/dd/yyyy)*	Social security number

I have elected: *(Mark the box which describes the election you have made with regard to your current spouse.)*

☐ a. No regular or insurable interest survivor annuity for my current spouse. ***I understand that:***

- No survivor annuity will be paid to my spouse after my death,
- His/her health benefits coverage will terminate upon my death, and
- He/she will not be eligible to enroll in the Federal Long Term Care Insurance Program (FLTCIP) after my death.

☐ b. I am electing an insurable interest survivor annuity for my current spouse, but no regular survivor annuity for my current spouse. (I have completed Section F, item 4 on my Standard Form 2801 naming my current spouse.)

☐ c. A partial survivor annuity for my current spouse equal to 55% of $_____ a year.

Part 2 - To Be Completed by the Current Spouse of the Retiring Employee

I freely consent to the survivor annuity election described in Part 1. ***I understand that if my spouse elected no regular or insurable interest survivor annuity in Part 1 above, after my spouse dies I will not receive a survivor annuity, my health benefits coverage will terminate when my spouse dies, and I will not be eligible to enroll in the Federal Long Term Care Insurance Program (FLTCIP) if I am not already enrolled before my spouse's death. I also understand that my consent is final (not revocable).***

Name *(type or print)*	Signature *(do not print)*	Date *(mm/dd/yyyy)*

Part 3 - To Be Completed by a Notary Public or Other Person Authorized to Administer Oaths

I certify that the person named in Part 2 presented identification (or was known) to me, gave consent, signed or marked this form and acknowledged that the consent was freely given in my presence on this

the _____ day of _____ *(Month)*, _____ *(Year)*, at _____ *(City and State)*.

(Seal of Notary Public or witnessing authority of person authorized to administer oaths)	Signature *(do not print)*
(Seal)	Expiration date *(mm/dd/yyyy)* of commission, if Notary Public

OPM 1515 – MILITARY SERVICE DEPOSIT ELECTION

Military Service Deposit Election

Employee's name *(last, first, middle)*	Date of birth *(mm/dd/yyyy)*	Social Security Number

Does the employee appear to be eligible for the guaranteed minimum annuity under the Civil Service Retirement System (CSRS) disability provisions?

☐ Yes → Would a deposit for military service increase the annuity? ☐ Yes

☐ No ☐ No

Instructions to Employee:

Your decision about making this deposit may affect your rights under CSRS or the Federal Employees Retirement System (FERS).

1. Please read the attached "Information for Completing OPM Form 1515" carefully to be sure you understand the consequences of not making the deposit for military service.
2. If you decide to make the deposit for military service, ask for instructions from the human resources office identified below.
3. Check the appropriate box below to indicate whether you will pay the deposit and return two copies of this form to the human resources office at the address below.

Return the completed election form to the agency human resources office listed below:

Agency name and address	Election must be received by *(mm/dd/yyyy)*

Employee Election

I have read the information concerning my rights to make a deposit for post-1956 military service. (Mark an "x" in the appropriate box below to indicate your election.)

☐ I want to pay (or complete) this deposit. I will make the necessary payment to my employing agency.

☐ I do not want to pay (or complete) this deposit. **(I understand this decision is irrevocable.)**

Signature *(Please do not print)*	Date *(mm/dd/yyyy)*

Instructions to Employing Office:

This form must be completed when an employee retires and agency records show that the employee has not made or completed a deposit for post-1956 military service. Give the employee three (3) copies of this form and these instructions for completing the form. Have the employee return two (2) signed and dated copies of the form. Attach one to the employee's records when you send them to the Office of Personnel Management (OPM). If the employee does not return a signed copy before you forward the records to OPM, please check the appropriate box below. The employee should also be counseled regarding the minimum basic annuity if the payment of the deposit will not increase the annuity.

☐ Employee **did not** return election form. ☐ Signed and dated copy attached

U.S. Office of Personnel Management
CSRS/FERS Handbook for Personnel and Payroll Offices

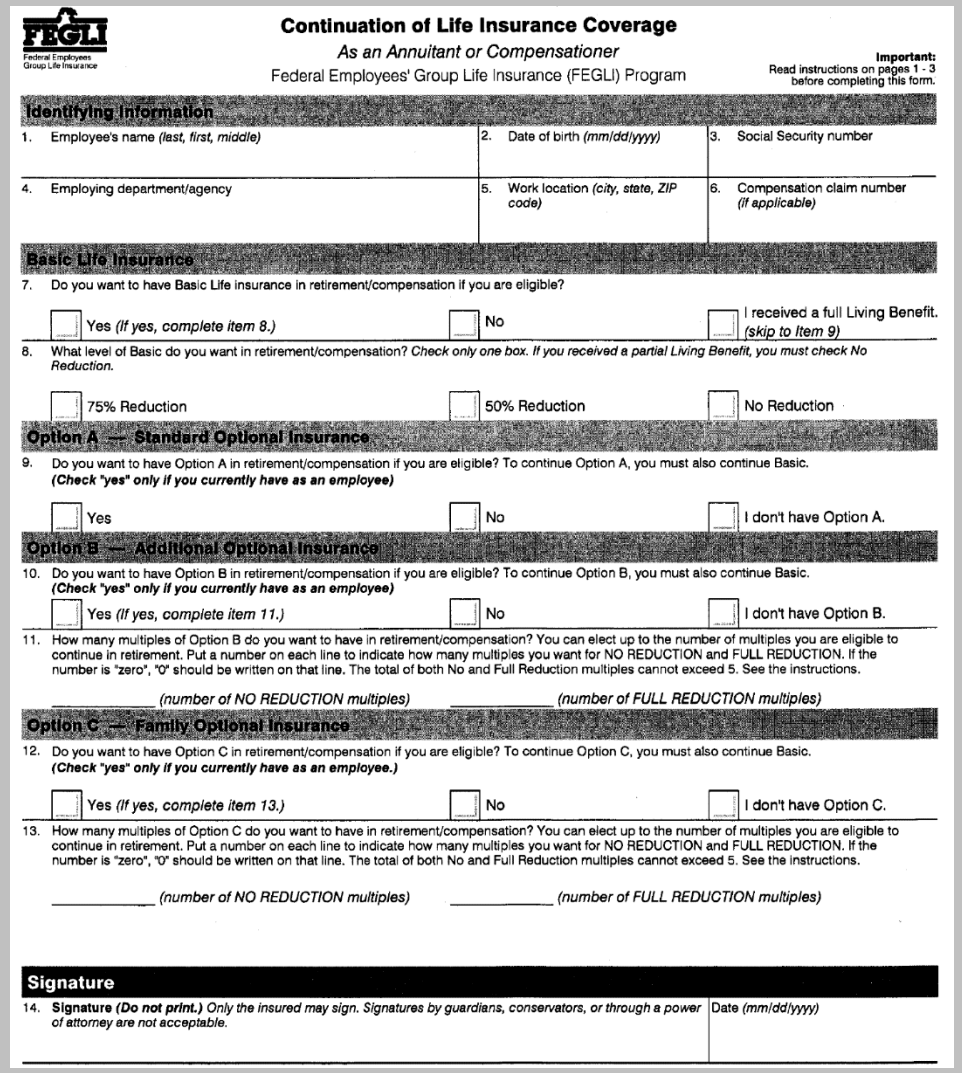
Reproduce Locally

1

OPM Form 1515
December 2000
Previous editions are not usable.

Clear Form Print Form Save Form

SF 2818 – CONTINUATION OF LIFE INSURANCE COVERAGE



FEGLI
Federal Employees Group Life Insurance

Continuation of Life Insurance Coverage

As an Annuitant or Compensationer

Federal Employees' Group Life Insurance (FEGLI) Program

Important: Read instructions on pages 1 - 3 before completing this form.

Identifying Information

1. Employee's name *(last, first, middle)*	2. Date of birth *(mm/dd/yyyy)*	3. Social Security number
4. Employing department/agency	5. Work location *(city, state, ZIP code)*	6. Compensation claim number *(if applicable)*

Basic Life Insurance

7. Do you want to have Basic Life insurance in retirement/compensation if you are eligible?

☐ Yes *(If yes, complete item 8.)* ☐ No ☐ I received a full Living Benefit. *(skip to Item 9)*

8. What level of Basic do you want in retirement/compensation? *Check only one box. If you received a partial Living Benefit, you must check No Reduction.*

☐ 75% Reduction ☐ 50% Reduction ☐ No Reduction

Option A — Standard Optional Insurance

9. Do you want to have Option A in retirement/compensation if you are eligible? To continue Option A, you must also continue Basic. ***(Check "yes" only if you currently have as an employee)***

☐ Yes ☐ No ☐ I don't have Option A.

Option B — Additional Optional Insurance

10. Do you want to have Option B in retirement/compensation if you are eligible? To continue Option B, you must also continue Basic. ***(Check "yes" only if you currently have as an employee)***

☐ Yes *(If yes, complete item 11.)* ☐ No ☐ I don't have Option B.

11. How many multiples of Option B do you want to have in retirement/compensation? You can elect up to the number of multiples you are eligible to continue in retirement. Put a number on each line to indicate how many multiples you want for NO REDUCTION and FULL REDUCTION. If the number is "zero", "0" should be written on that line. The total of both No and Full Reduction multiples cannot exceed 5. See the instructions.

_____ *(number of NO REDUCTION multiples)* _____ *(number of FULL REDUCTION multiples)*

Option C — Family Optional Insurance

12. Do you want to have Option C in retirement/compensation if you are eligible? To continue Option C, you must also continue Basic. ***(Check "yes" only if you currently have as an employee.)***

☐ Yes *(If yes, complete item 13.)* ☐ No ☐ I don't have Option C.

13. How many multiples of Option C do you want to have in retirement/compensation? You can elect up to the number of multiples you are eligible to continue in retirement. Put a number on each line to indicate how many multiples you want for NO REDUCTION and FULL REDUCTION. If the number is "zero", "0" should be written on that line. The total of both No and Full Reduction multiples cannot exceed 5. See the instructions.

_____ *(number of NO REDUCTION multiples)* _____ *(number of FULL REDUCTION multiples)*

Signature

14. **Signature *(Do not print.)*** *Only the insured may sign. Signatures by guardians, conservators, or through a power of attorney are not acceptable.*	Date *(mm/dd/yyyy)*

W-4P – WITHHOLDING CERTIFICATE FOR PENSION OR ANNUITY PAYMENTS

---------- Cut here and give Form W-4P to the payer of your pension or annuity. Keep the top part for your records. ----------

Form **W-4P**

Department of the Treasury
Internal Revenue Service

Withholding Certificate for Pension or Annuity Payments

► For Privacy Act and Paperwork Reduction Act Notice, see page 4.

OMB No. 1545-0074

Type or print your first name and middle initial.	Last name	**Your social security number**
Home address (number and street or rural route)		Claim or identification number (if any) of your pension or annuity contract
City or town, state, and ZIP code		

Complete the following applicable lines.

1 Check here if you **do not want any** federal income tax withheld from your pension or annuity. (Do not complete lines 2 or 3.) ► ☐

2 Total number of allowances and marital status you are claiming for withholding from each **periodic** pension or annuity payment. (You may also designate an additional dollar amount on line 3.) . . . . . ► _____ (Enter number of allowances.)

Marital status: ☐ Single ☐ Married ☐ Married, but withhold at higher "Single" rate

3 Additional amount, if any, you want withheld from each pension or annuity payment. (**Note.** *For periodic payments, you cannot enter an amount here without entering the number (including zero) of allowances on line 2.)* . . ► $

Your signature ► **Date** ►

CSRS DISABILITY APPLICATION

Submit all of the previous forms and:

- **SF 3112A** Applicant's Statement of Disability
- **SF 3112B** Supervisor's Statement
- **SF 3112C** Physician's Statement
- **SF 3112D** Agency Certification of Reassignment and Accommodations Efforts
- **Medical Evidence**
- **Copy of last performance appraisal**
- **Copy of position description**
- **Proof of application for Social Security Disability Benefits (If CSRS Offset)**
- **FEDMER Statement (If CSRS Offset)**

SF 3112 A
APPLICANT'S STATEMENT OF DISABILITY

Applicant's Statement of Disability

In Connection With Disability Retirement Under the Civil Service Retirement System or the Federal Employees' Retirement System

Civil Service Retirement System

Federal Employees' Retirement System

A copy of this completed form must accompany the Supervisor's Statement that you give your supervisor(s).

1. Name *(last, first, middle)*	2. Date of birth *(mo./day/yr.)*	3. Social security number

4. Fully describe your disease(s) or injury(ies.) We consider only the diseases and/or injuries you discuss in this application.

5. Describe how your disease(s) or injury(ies) interferes with performance of your duties, your attendance, or your conduct.

6. Describe any other restrictions of your activities imposed by your disease or injury.

7a. What accommodations have you requested from your agency?

7b. Has your agency been able to grant your request? *(Attach an explanation or any documentation that you have regarding accommodation.)*

☐ Yes ☐ No

SF 3112 A (CONTINUED)

7c. What is your current status with your agency?

- ☐ In pay status; and working without accommodation.
- ☐ In pay status; and working with accommodation
- ☐ In leave without pay status. *
- ☐ Separated from service*

**If you are currently in a leave without pay status or separated from service, what job(s), if any, have you performed since going into this status. Please explain the physical and/or mental requirements for this (those) job(s).*

8. Give the approximate date you became disabled for your position *(mo./yr.)*.	9. Have you been hospitalized for your disease or injury as described in item 4? ☐ Yes ☐ No	10. Give date of most recent hospitalization. From *(mo./yr.)*	To *(mo./yr.)*

11. *Notice for FERS and CSRS Offset Applicants ONLY*

Application for disability retirement under FERS or CSRS Offset requires an appliation for Social security Disability Benefits. Final Processing at OPM cannot be completed without a copy of your Social Security application receipt or award notice.

11a. Have you applied for disability benefits from the Social Security Administration?	11b. Is the application receipt or award notice attached?
☐ Yes ☐ No	☐ Yes ☐ No

SF 3112 A (CONTINUED)

12. List physician(s), (name(s), address(es), and dates of treatment) from whom you plan to request Physician's Statements (SF 3112C)). Attach an additional sheet if you wish to list more physicians.

Name	Address	Date of Treatments

Applicant's Consent and Certification	I certify that all statements made above are true to the best of my knowledge and belief. I give my permission for the release of information about my service and medical condition(s)(i.e., disease or injury) to authorized agency and OPM officials. I have read and understand all of the information provided in the instructions to this application.	
WARNING: Any intentionally false statement in this application or willful misrepresentation relative thereto is a violation of the law punishable by a fine of not more than $10,000 or imprisonment of not more than 5 years, or both. (18 U.S.C. 1001)	Signature *(Do not print)*	
	Date *(mo./day/yr.)*	Daytime telephone number *(incl. area code)*

SF 3112 B
SUPERVISOR'S STATEMENT

You should ask your supervisor to complete this form. It should be returned to you to submit with the rest of the application.

Your supervisor will answer questions regarding your performance, attendance, conduct and any accommodation or reassignment efforts that have been attempted due to illness or injury.

A copy of the last performance appraisal and the employee's position description also needs to be provided by your supervisor.

SF 3112 C
PHYSICIAN'S STATEMENT

Physician's Statement

In Connection With Disability Retirement Under the Civil Service Retirement System and the Federal Employees' Retirement System

Civil Service Retirement System

Federal Employees' Retirement System

Applicant must attach a copy of the most current position description

Form Approved: OMB No. 3206-0228

Section A - Identifying Information and Consent
(to be completed by applicant)

1. Applicant's Name *(last, first, middle)*	2. Date of birth *(mo./day/yr.)*	3. Social security number

If you are currently employed by your agency or separated for less than 30 days, enter exact name and address including the name of the person or office in your employing agency where this information should be mailed. →	4. Enter exact name and address *(including ZIP Code)*.
If you have been separated from your employing agency for 31 days or more provide your current home address. →	
Applicant's Consent to Release Medical Information	**5. I authorize the release to the Office of Personnel Management and my employing agency of any and all information or records connected with my disability retirement application.**
	Signature *(do not print)* / Date *(mo./day/yr.)*

SF 3112 D
AGENCY CERTIFICATION OF REASSIGNMENT AND ACCOMODATIONS EFFORTS

You should ask your servicing Civilian Personnel Advisory Center, CPAC, or Human Resources Office, HRO to complete this form.
Once completed it should be returned to you to submit with the rest of the application.

The CPAC or HRO will answer questions about the agency's accommodation and/or reassignment efforts.

FEDMER
SOCIAL SECURITY DISABILITY

ELIGIBILITY STATEMENT

Exhibit – FEDMER Social Security Disability Eligibility Statement

Federal Medical Evidence of Record (FEDMER)
Social Security Disability Eligibility Statement
Keep a copy of this form

Name_____SSN_____

Please put a check mark in the box next to the number that describes your situation, and follow the instructions for that section.

☐ 1. I am already receiving Social Security disability benefits. I will provide my Human Resource office with proof (e.g. copy of my Social Security Award Certificate).

☐ 2. I have filed for Social Security disability benefits, but I have not received a decision. I will provide my Human Resource office with proof (e.g., copy of Social Security disability application receipt, copy of the ISBA page "What You Need to Do Now", etc.).).

If you checked either #1 or #2 above, sign and date the statement below, and return it to your Human Resource office with the documentation indicated. **Do not check any further blocks, or take any other action.**

My signature below verifies my status.

Signature: _____ Date: _____

FEDMER
SOCIAL SECURITY DISABILITY

ELIGIBILITY STATEMENT

If you have not checked Box 1 or 2, above, please check Box 3 and follow the instructions.

☐ 3. I have not filed for Social Security disability benefits, OR I have filed and have been denied. Since I am now filing for FERS disability, I understand I also need to file for Social Security disability benefits.

If you checked block #3, you need to apply for Social Security disability using either the:

- **Internet** to complete the *"Online Adult Disability Report"* **and** the "*Online Application for Social Security benefits*" at http://www.socialsecurity.gov/applyfordisability/adult.htm OR

- **Contact Option**: Contact Social Security to schedule an appointment to file your Social Security disability claim. You can call Social Security's national toll-free telephone number (1-800-772-1213) or contact your local Social Security office. When you make your appointment, Social Security will provide you with an "Adult Disability Starter Kit" that you can use to prepare for your interview. You can also see the starter kit at the Internet site shown above.

Whether you use the Internet or the Contact Option to file, a Social Security representative will contact you to complete your disability application. At that time you will need to provide to Social Security a **copy of this form and a copy of any medical records you have obtained for your FERS disability claim.**

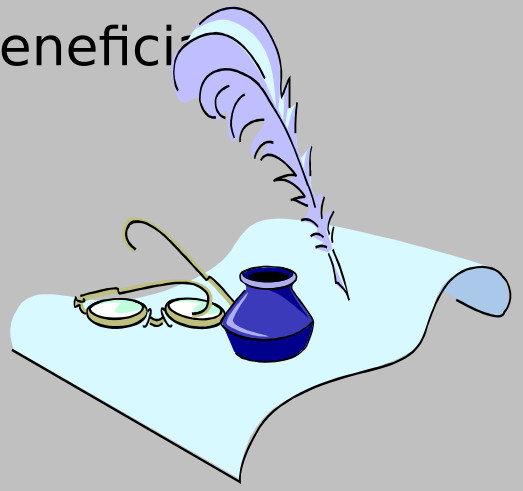
When you file your disability application, Social Security will provide you with a receipt. You must provide your Human Resource office with a copy of the application receipt, which is needed by them in order to complete the processing of your FERS disability application.

BENEFICIARY FORMS

- SF 2823 Designation of Beneficiary-
  Federal Employees' Group Life Insurance Program

- SF 2808 Designation of Beneficiary-
  Civil Service Retirement System

- TSP-3 Thrift Savings Plan-Designation of Beneficiary

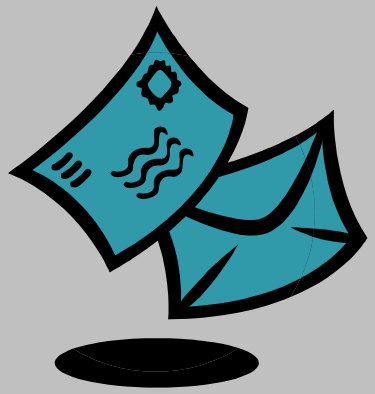


WHERE DO I SEND THE FORMS ?

All forms and documentation should be submitted to:

ARMY BENEFITS CENTER-CIVILIAN
305 MARSHALL AVE
FORT RILEY, KS 66442-5004

1-877-276-9287
Or
1-877-276-9833 (TDD)



REMEMBER: We must have original forms!